THE RECOVERY KERNEL

How to Navigate the Recovery Kernel

For People Recovering from Psilocybin

Psilocybin mushrooms, truffles, edibles, and microdosing. A step-by-step route: what to read, in what order, and what outcome the Kernel projects if you follow it. Supervised therapeutic psilocybin is a different context, addressed in Step 8.

> **HARM REDUCTION RESOURCE — NOT MEDICAL ADVICE. Psilocybin does not cause physical dependence or withdrawal, and stopping is not a medical event.** The dangers are psychological and behavioral: the Kernel says psilocybin alone does not cause respiratory depression, cardiac events, or overdose death at doses documented in the literature. The emergencies are a psychiatric break, dangerous actions during a frightening experience, and misidentified poisonous mushrooms.
>
> **Get urgent psychiatric help or call 911 if:** you have lost track of what is real, hear commands or voices, feel persecuted, or are a danger to yourself or others, whether or not you have used recently. Persistent visual phenomena where you still know they are not real are usually HPPD (Step 7), not psychosis. Severe stomach pain, vomiting, or liver symptoms after eating wild mushrooms can be poisoning: go to an emergency department. **A personal or family history of schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis is an absolute contraindication.**
>
> Crisis: call or text 988 · SAMHSA: 1-800-662-4357

1. Before you start

This is a route through the Recovery Kernel for people whose relationship with psilocybin has become a problem, and for the people supporting them. By every conventional addiction measure psilocybin scores extremely low: there is no physical dependence, essentially no dopamine reward mechanism, and rapid tolerance that blunts repeated use. The Kernel says the problems that develop are different, and they set the order of this guide. The Kernel's frame is that the mushroom showed you something real, and that recovery is learning to reach it without help. Six rules follow.

- **Integration is the main work.** The typical problem is experiences arriving faster than they can be turned into meaning: an integration backlog that produces anxiety, confusion, and instability, even when sober.
- **Screen for psychosis risk first.** The Kernel calls the contraindication absolute for anyone with a personal or family history of psychotic illness, regardless of dose or setting, and says if psychosis has been triggered, psychiatric care is the primary track.
- **Know HPPD from psychosis.** HPPD (persisting visual phenomena) is generally benign and usually fades, and the giveaway is that you still know the phenomena are not real. Cannabis is its most reliable aggravator.
- **Sleep and cannabis first.** Stopping all psychedelics and cannabis, and repairing sleep, are the biological foundation. There is no detox to design.
- **The compound is not the packaging.** The Kernel says psilocybin (converted to psilocin) is the active thing. Mushroom potency varies widely by species and

batch, so a bad experience may have reflected a much higher dose than you thought.

- **Do not wait for test results to start.** The genome refines the plan (Main Book, Quick-Start Step 3; Supp. Ch. 5, Step 1b).

How chapters are cited. "Main Book" is the Recovery Kernel Main Book (Second Edition, Centurian). "Compendium" is the Complete Protocol Compendium. "Supp. Ch. N" is chapter N of the Supplemental Book. The core chapter is Chapter 27 (How to Recover from Psilocybin), which explicitly builds on Chapter 26 (How to Recover from LSD) for the recovery framework (§3), HPPD (§4), integration (§5), and natural access (§6). Section numbers (§) refer to sections inside those chapters.

> **A note on protocol numbers.** Supplemental Chapter 27 leans on Chapter 26 (LSD), and both cite Compendium protocols by number. Some numbers do not match the Compendium as printed. They call Protocol 04 "Dharma Recovery" (printed: Meeting Alternatives), Protocol 03 "exercise" (printed: Sonic Architecture; exercise is Protocol 19), Protocol 22 the nature protocol (printed: The Family Field), Protocol 17 "sleep" (printed: The Nightly Restoration), Protocol 05 a stabilization protocol (printed: Digital Detox), Protocol 20 the identity protocol (printed: Mapping the Terrain), and Centurian Paper C-28 correctly (The Recast). They also send genomic mapping to "Section 15 (Compendium)". This guide cites each protocol by its printed title. If a number and a title disagree, follow the title.
>
> For psilocybin, watch for redosing in the first hour when the onset seems slow — the ambiguous early window is exactly when a second dose creates a far bigger experience than intended.
>
> Redosing is not the only version of this. Watching peers in a treatment setting negotiate a relapse, getting confident advice from someone untrained in your specific situation, or noticing a prescriber treat a prescribed substance more casually than an illicit one can all trigger the same pattern: a felt doubt read as “the plan must be wrong,” answered by abandoning it. See **The Commandeering Map**, a companion to this series, for the fuller pattern, including how it can differ by genetic profile and what helps when practice-based resistance alone is not enough.

2. The route at a glance

Steps 0 and 1 come first. Steps 2 to 4 can run at the same time. Steps 5 to 9 overlap and are the work of the first two years. Step 10 is everything after. "P" means Compendium Protocol; "C" means Centurian Paper.

Step	When	What you do	Turn to
0	Day 0	Triage: psychosis history, current symptoms, mushroom identification, medications.	Supp. Ch. 27 §0 Supp. Ch. 26 §0, §2 Main Book, Quick-Start Step 1
1	Weeks 1–4	Stop all psychedelics and cannabis. Sleep first. Track any visual phenomena.	Supp. Ch. 27 §3; Ch. 26 §3 Supp. Ch. 26 §7 Compendium P01

Step	When	What you do	Turn to
2	Weeks 1–4	Read the Main Book in order.	Main Book: Who This Book Is For, Quick-Start, Part One (Ch. 1–5) Supp. Ch. 2, 3
3	Weeks 1–4	Order 30× whole-genome sequencing. Add a clinical PGx panel and baseline labs.	Supp. Ch. 5 Step 1 Supp. Ch. 27 §2; Ch. 26 §2 Compendium P06
4	Weeks 2–6	Resolve your profile. Work out what the sessions were giving you.	Supp. Ch. 5 Steps 2–3, 6 Supp. Ch. 27 §2
5	Day 1 to Month 6	Build the foundation: methylation, serotonin support (with a wait), BDNF.	Supp. Ch. 27 §4 Supp. Ch. 5 Phase One Compendium P07, P17, P18
6	Weeks 1–8, then ongoing	The integration sprint: journal, therapist, body work, community.	Supp. Ch. 27 §5 Supp. Ch. 26 §5 Compendium P08
7	If present	HPPD, depersonalization, and the line to psychosis.	Supp. Ch. 26 §4, §8 Supp. Ch. 27 §0.3
8	From week 2	Microdosing. Underlying depression, anxiety, or ADHD. The therapeutic psilocybin question.	Supp. Ch. 27 §4.4, §7 Compendium P13, P42
9	Months 1–12+	Build natural access: meditation, emotional vulnerability, awe, creative flow.	Supp. Ch. 27 §6 Supp. Ch. 26 §6; C-28 Compendium P19, P29
10	Months 3+, Year 1 to 10	The meaning crisis, identity, and stewardship.	Supp. Ch. 26 §5.4; Ch. 42, 43, 44 Compendium C-28, P24, P25 Supp. Ch. 5 Step 6

3. The route, step by step

Step 0 — Triage (Day 0, before everything)

Start with psychosis. Ask honestly: is there a personal or family history of schizophrenia, schizoaffective disorder, or bipolar disorder with psychosis; has psilocybin or any psychedelic ever left you unable to tell what was real, or left symptoms after it wore off? The Kernel names COMT Met/Met plus DRD2 A1 plus a psychiatric family history as its highest-risk combination, but says your history is what decides. If any of it applies, get a psychiatric evaluation. The Kernel says the psychiatric track is primary and this guide only supports it.

Then the practical points. If you are having a frightening experience right now, the Kernel's advice is a quiet, dim, familiar room, one calm sober person, surrender rather than fighting, and a physician or emergency service only if there is danger or a psychiatric break. It names benzodiazepines as the medical tool for severe anxiety during a session, which is a clinician's decision. Wild-foraged mushrooms carry a species-misidentification risk that can be fatal, so persistent severe stomach or liver symptoms are an emergency. MAOIs and tramadol together with psilocybin can cause serotonin syndrome, while the Kernel says SSRIs mainly dampen psilocybin rather than causing a dangerous excess.

> **A caution this guide adds (not in the Kernel).** Ask your prescriber about any psychiatric medication before any future psychedelic session, and do not assume a drug is safe because the Kernel does not mention it. Lithium in particular has been associated with serious reactions when combined with psychedelics in survey reports.

Turn to: Supp. Ch. 27 §0 (immediate safety: the difficult experience; what psilocybin is not; what it can cause; harm reduction for active use). Supp. Ch. 26 §0 (the bad trip protocol; the sitter role) and §2 (who should not use). Main Book, Quick-Start Boot Sequence, Step 1. Compendium Protocol 01, Emergency Triage, for an acute crisis state.

Step 1 — Stop, stabilize, and sleep (Weeks 1–4)

There is no withdrawal, so the first month is about removing what perpetuates the problem and repairing sleep. Stop all psilocybin and every other 5-HT2A agonist (LSD, DMT, mescaline), because the receptor system cannot recover while it is under active stimulation. Stop cannabis at the same time: the Kernel calls it the most reliably reported HPPD and depersonalization aggravator, and many people improve within weeks of stopping. Repair sleep first, since psilocybin disrupts sleep architecture in the days after a high-dose session, and sleep is when receptor density recovers. Begin the methylation foundation from day 1. Keep a brief record of any visual phenomena to see the trajectory.

The aftermath timeline the Kernel gives: days 1 to 3 are the afterglow, with elevated BDNF, the best window for integration work, and a shorter window than LSD (peaking in the first 24 to 48 hours). Week 1: HPPD assessment if relevant, and sleep monitoring. Weeks 2 to 8: integration is the primary activity, and HPPD, if present, often eases. Months 1 to 6: receptor density recovering, HPPD resolving for most, and meaning beginning to metabolize into life. Months 6 to 24 and beyond: most HPPD substantially resolved, integration continuing as an ongoing process.

Turn to: Supp. Ch. 27 §3 (psilocybin-specific differences from LSD; the aftermath timeline). Supp. Ch. 26 §3 (the recovery framework; the aftermath timeline) and §7 (the protocol map). Compendium Protocol 01, Emergency Triage.

Step 2 — Read the Main Book (Weeks 1–4)

Read it in order once you are settled. If you are overwhelmed, the Quick-Start Boot Sequence is designed to be read on its own. Read "Who This Book Is — and Is Not — For" first: it names situations where the supplement protocols need medical modification, including active psychosis, pregnancy, and severe liver disease.

Read in this order: Who This Book Is For → Quick-Start Boot Sequence → Part One: Ch. 1 (Why Willpower Isn't Enough), Ch. 2 (MTHFR), Ch. 3 (COMT), Ch. 4 (CYP450), Ch. 5 (When Systems Collide) → Part Two, the case files (Chapter 6). Ch. 8 (Oxytocin Protocol) is experimental and specialist-only. Ch. 9 (Epigenetic Playground) belongs to Steps 9 and 10. Appendix A and Appendix B are reference.

Then add: Supp. Ch. 2 (Clarity · Restoration · Manning). The Kernel has no psilocybin case study. The nearest are Case 06 (MDMA, a serotonin-system profile) and Case 09 (ketamine, a trauma and dissociation profile). Supp. Ch. 26 (How to Recover from LSD), which Chapter 27 tells you to read alongside it. Supp. Ch. 3 (The Addict Virgin Problem) recalibrates timelines for a damaged system. Supp. Ch. 1 (Why They Left You There) is optional reading for the shame.

Step 3 — Get your DNA (Weeks 1–4)

The Kernel's recommended route is 30× whole-genome sequencing, which returns a VCF file, a one-time asset you keep. A consumer SNP array is an acceptable start. Homocysteine, B12, and RBC folate are functional markers you can recheck quarterly.

Psilocybin's genomics is simpler than most, because it is converted by phosphatase enzymes, not the CYP450 system, so the Kernel says CYP2D6 and CYP3A4 are not significant for psilocybin itself. (CYP3A4 does matter if LSD was part of your use.) The gene that matters most is **HTR2A**, the 5-HT2A receptor psilocin acts on: high-expression variants make the same dose feel more intense and likely raise HPPD risk. Next come **COMT** (Met/Met with a family history of psychosis is the Kernel's highest-risk profile), **MTHFR**, **SLC6A4**, **BDNF**, and, from the LSD panel, **DRD2/ANKK1** and **FKBP5**. HTR2A is not on standard consumer panels, and the Kernel says it needs a pharmacogenomic lab. Until results arrive: did psilocybin consistently feel more intense than for others at the same dose; were your experiences emotionally overwhelming more than visually; did it fix a chronic low mood that nothing else touched (suggesting an MTHFR-related serotonin deficit); did you develop visual phenomena; did it do very little for you (possibly an SSRI effect)?

> **Confirm what you are ordering.** Supp. Ch. 5 specifies 30× whole-genome sequencing with VCF output. "WGBS" more commonly names whole-genome bisulfite sequencing, a DNA-methylation assay that is not built to call variants such as MTHFR C677T. Ask the lab for a standard variant file (VCF).

Turn to: Supp. Ch. 5, Step 1. Supp. Ch. 27 §2 (the genomic blueprint; phenotyping without testing). Supp. Ch. 26 §2 (the full LSD panel, including the psychosis contraindication). Compendium Protocol 06, Phenotype Assessment. Main Book Ch. 2 and Ch. 3 self-assessments.

Step 4 — Resolve your profile (Weeks 2–6)

Write your profile down and carry key results on a card. The Kernel's question is what the sessions were giving you: for many people a real emotional, depressive, or existential need, and for a subset a serotonin-synthesis deficit that 5-MTHF addresses more directly than any session did.

If your result is...	What changes	Source
HTR2A high-expression	More intense experiences at the same dose, and likely higher HPPD risk with frequent use. The "sensitivity" some people report is largely this gene.	Supp. Ch. 27 §2; Ch. 26 §2
COMT Met/Met plus psychiatric family history	The Kernel's highest-risk constitutional profile for destabilizing experiences and psychosis. Anxiety management is the concurrent primary target, and a comprehensive risk assessment is needed before any therapeutic session.	Supp. Ch. 27 §2, §7; Ch. 26 §2
DRD2 A1 with Met/Met COMT	The Kernel's highest LSD psychosis-risk combination, and it applies by analogy here. Neither variant alone defines the risk.	Supp. Ch. 26 §2
MTHFR variants	A serotonin-synthesis deficit that the sessions flooded past. 5-MTHF is often transformative for the depression or anxiety that drove use, and should be assessed before an SSRI trial.	Supp. Ch. 27 §2, §4.1; Main Book Ch. 2
SLC6A4 short/short	A serotonin environment with lower baseline tone and higher sensitivity, which may make emotional content more intense. Relevant to the underlying anxiety or depression.	Supp. Ch. 27 §2
BDNF Met	Reduced BDNF secretion may mean a shorter or weaker neuroplastic afterglow, so exercise matters more during integration.	Supp. Ch. 27 §2
FKBP5 / stress-response variants	An exaggerated stress response, especially with trauma history, makes surfaced material harder to integrate and raises the risk of acute crisis. Trauma history is a specific caution.	Supp. Ch. 26 §2

Turn to: Supp. Ch. 5, Steps 2, 3, and 6 (gene systems, combined profiles, profile template). Supp. Ch. 27 §2. Main Book Ch. 5 and Appendix A.

Step 5 — Build the foundation (Day 1 to Month 6)

Because there is no physical dependence, the Kernel says the foundation is simpler than for most substances. Methylation first: 5-MTHF, methylcobalamin, active B6, and magnesium. Serotonin support: 5-HTP, but the Kernel says to wait 3 to 5 days after any session so the receptor system can finish its natural recovery, and never to combine it with serotonergic medication; also inositol, omega-3, and EGCG. Then the neuroplastic window: the Kernel says psilocybin raises BDNF for days, and the best supports are vigorous daily exercise (strongest in the 48 hours after a session), lion's mane, deep sleep, and NAC. Note that guides differ on the 5-HTP wait (the MDMA guide says 2 to 3 days), so follow your physician. The dose tables are in the chapter below. Run every addition past a pharmacist and an interaction checker (Drugs.com or Medscape).

Turn to: Supp. Ch. 27 §4.1 (methylation), §4.2 (serotonin system support, with the 5-HTP warning), §4.3 (BDNF and the neuroplastic window). Supp. Ch. 26 §4.3 (HPPD-supporting antioxidants). Supp. Ch. 5, Phase One. Main Book Ch. 2, §2.4–2.5. Compendium Protocol 07 (Neuroplasticity), Protocol 17 (The Nightly Restoration), Protocol 18 (Eating for Restoration), and Centurian Paper C-32 (The Insomnia Architecture).

Step 6 — The integration sprint (Weeks 1–8, then ongoing)

Integration is turning a raw experience into updated understanding, changed behavior, or processed emotion. It is not having another experience to make sense of the last one, which the Kernel calls the trap that produces accumulation instead of resolution. Signs of a backlog: trouble telling what the sessions revealed from what they produced, an altered quality to ordinary perception when sober, unexplained anxiety, difficulty organizing thoughts or keeping a consistent worldview, and a sense that something important was met but cannot be reached.

Psilocybin surfaces more specific personal and relational material than LSD, so the Kernel says integration here is more psychotherapy-like: grief, family patterns, particular memories. Its toolkit: journal within 2 to 4 hours of a session's end, describing before interpreting; body-based work (somatic therapy, yoga, dance), because the body holds what the mind has not processed; a psychedelic-informed therapist, who is more central here than for LSD, neither pathologizing the experience nor validating everything as revelation; and integration circles. Its four-step emotional-content protocol: name the content specifically ("I saw my relationship with my father as a pattern of seeking approval I never received, and I grieved it"), identify the real relationship or pattern it points at, act on what it indicated, and take the material to therapy, since the session surfaces it and integration resolves it.

Turn to: Supp. Ch. 27 §5 (the psilocybin-specific integration toolkit; the emotional content protocol). Supp. Ch. 26 §5 (what integration is and is not; the backlog; the toolkit). Compendium Protocol 08 (Social Environment).

Step 7 — HPPD, depersonalization, and the line to psychosis (if present)

The Kernel's definition of HPPD: visual phenomena that persist after use, such as visual snow, afterimages and trails, geometric patterns, and halos, usually benign and usually fading, and more common with heavy or frequent psychedelic use. What separates it from psychosis is intact reality testing: you know the phenomena are not real objects, and asking "is this real?" is itself evidence of that. HPPD does not include voices, command hallucinations, or persecutory beliefs, and it worsens with anxiety, cannabis, fatigue, and stress. The Kernel puts prevalence at about 4 to 5 percent of psychedelic users, with risk rising with frequency, high doses, combining psychedelics, cannabis co-use, prior anxiety, and prior head injury.

The Kernel's HPPD approach: accurate understanding first, because terror amplifies the symptoms; complete cessation of all psychedelics and of cannabis; anxiety management (4-7-8 breathing, magnesium, L-theanine, exercise); sleep, with screens off for two hours before bed and darkness and visual rest; and the antioxidant supports. For severe, impairing cases the Kernel names clonazepam (short-term only, because of dependence risk) and lamotrigine as options for a prescriber, and cautions that SSRIs may worsen visual phenomena and that conventional antipsychotics have been reported to. Those are specialist decisions with limited evidence. Depersonalization and derealization (feeling detached from yourself or the world, with reality testing intact) are driven mainly by anxiety and worsened by cannabis, alcohol, caffeine, and sleep loss. The Kernel's management is grounding, anxiety reduction, stopping all substances, and, if persistent, psychiatric referral for DPDR-informed therapy. Get urgent evaluation for any lost reality testing, command hallucinations, persecutory beliefs, or disorganized thinking that does not respond to grounding.

Turn to: Supp. Ch. 26 §4 (HPPD: what it is and is not; prevalence and risk factors; the management protocol; medication; depersonalization and derealization) and §8.1 (medical priorities). Supp. Ch. 27 §0.3 and §1.4.

Step 8 — Microdosing, underlying conditions, and therapeutic psilocybin (from week 2)

Microdosing (a sub-perceptual amount, often 1 to 3 days a week) does not carry the HPPD, integration, or psychosis risks of higher amounts, per the Kernel, but it can develop its own compulsion. Three patterns: intolerance of sober days (the ordinary state feels flat or aversive by contrast); dose escalation toward perceptual effects, at which point it is low-dose use and the full framework applies; and a masked underlying condition, with the microdose managing depression, ADHD, or anxiety that was never diagnosed. The response is planned sober periods extended gradually, 5-MTHF and exercise as sober-state support, and assessment of what the microdose was treating. Treat that condition directly: 5-MTHF for MTHFR variants, non-stimulant treatment if ADHD is confirmed, and a psychiatric evaluation for depression.

> **Therapeutic psilocybin: the status is changing.** The Kernel describes psilocybin therapy as the most clinically advanced psychedelic model, with state programs in Oregon and Colorado. My check of current sources (July to September 2026): psilocybin is not FDA-approved and remains Schedule I federally. Compass Pathways' COMP360 for treatment-resistant depression has reported two positive Phase 3 trials and is under a rolling FDA application, with a priority voucher granted in April 2026, and Usona's psilocybin for major depression has a voucher too. I could not verify the Kernel's statements about legal options abroad. Verify before relying on any of it.
>
> The Kernel's position on using it if you have a use-disorder history: a decision for an addiction medicine specialist, the therapeutic facilitator, and a psychiatrist who knows both fields, with full disclosure of your history, HPPD and psychosis clearance, and an integration plan that addresses your use patterns. Current HPPD, a past psychosis-like response, and the COMT Met/Met plus psychiatric-family-history profile are contraindications or call for comprehensive assessment. It is not a categorical exclusion, and it is a categorical requirement for care.

Turn to: Supp. Ch. 27 §4.4 (microdosing) and §7 (the therapeutic psilocybin question). Supp. Ch. 26 §8.2 and §8.3 (therapeutic use; medications for anxiety, depression, and sleep). Compendium Protocol 13 (The Pharma Trap), and Protocol 42 (The Experimental Branch) for the Kernel's treatment of emerging interventions.

Step 9 — Build natural access (Months 1–12+)

The Kernel says the finding that best predicts psilocybin's therapeutic outcomes in trials is the intensity of the mystical-type experience (oceanic boundlessness, a sense of insight, sacredness, deep positive mood, timelessness, ineffability), and that each element has a slower, earned route. Meditation is the route to ego dissolution and absorption states: a systematic practice, at least 20 minutes daily, built up over months. Emotional openness, psilocybin's particular gift, is rebuilt through scheduled, deliberate vulnerability with safe people, therapy, and community that holds emotional truth, and the Kernel calls this the most personally demanding porting task. The felt sense of insight comes from sustained contemplative inquiry: reading of depth, philosophical and theological community, and writing as genuine inquiry. Sensory beauty is rebuilt by attentive engagement with music, nature, and art, not background exposure. Awe in nature, creative flow at the edge of competence, and contemplative tradition (one tradition's map, practiced consistently) complete it. The Kernel also notes psilocybin sits inside a ceremonial tradition of some 3,500 years, and that a container of healer, ritual, and community is what recreational use usually lacked.

> **A caution this guide adds (not in the Kernel).** Hyperventilation-based breathwork can provoke panic or dissociation in people with a psychosis history, seizure history, heart conditions, or persistent depersonalization. If any of those applies, ask your clinician before trying it, and start with meditation and grounding.

Turn to: Supp. Ch. 27 §6 (the mystical experience is replicable through earned roads). Supp. Ch. 26 §6 (the natural access points; the sonic architecture). Centurian Paper C-28 (The Recast). Compendium Protocol 04 (Meeting Alternatives, which the Kernel calls Dharma Recovery), Protocol 19 (The Body in Motion), Protocol 29 (The Peacetime Paradox).

Step 10 — The meaning crisis, identity, and the long game (Months 3+, Year 1 to Year 10)

For some people the hardest part is that the ordinary meanings that organized life (career, identity, relationships, beliefs) feel insufficient or arbitrary after repeated sessions. The Kernel says this is not illness. It is a genuine philosophical disruption, and it is sometimes the most important work of a person's life. It is held, not solved: contemplative traditions have mapped this territory for millennia. The identity question here differs from the usual one: not "who am I without the drug" but "what do I do with what it showed me?" Full Inventory is a structured 180-day plan, and Amends to Self puts the person who lived through it first. Family, money, and work follow. Navigation after the first two years shifts from repair to stewardship. Section 4 shows how. Standing tools: Supp. Ch. 44 (The Transplant: redirect the devotion and daily structure the pattern required into a practice that grows). Supp. Ch. 6 (Stay Non-Addicted) and Compendium Protocol 02 (Behavioral Addictions, with its "Mask Change" caution on addiction transfer). Compendium Protocol 13 (The Pharma Trap). Supp. Ch. 38. Supp. Ch. 5, Step 6 (a weekly AI check-in profile, a reasoning tool and never a provider).

Turn to: Supp. Ch. 26 §5.4 (the meaning crisis). Supp. Ch. 42 (Full Inventory). Supp. Ch. 43 (Amends to Self). Centurian Paper C-28 (The Recast). Compendium Protocol 24 (Returning to Work), Protocol 25 (The Open Door), Protocol 22 (The Family Field), Protocol 16 (The Isolation Spiral). Supp. Ch. 51 (Family & Support Network Guide): give it to the people who love you.

4. How navigation changes at Years 3, 5, and 10

Shading shows how much attention each track needs. Darkest is primary focus, then active, then maintenance. White cells with gray text are standing safeguards: low effort, never dropped. Numbers in brackets refer to the shifts listed below the table.

Track	Months 0–24 (foundation)	Year 3 (consolidate)	Year 5 (build out)	Year 10 (steward)
Safety and medical	Psychosis screen; HPPD watch	Mood plan; therapeutic decision [1]	Mood plan, clinician-led	Psychosis rule holds for life [7]
Biology and genome	HTR2A, COMT; 5-MTHF base	Retest labs; step stack to upkeep [2]	Prescriber card: HTR2A, COMT	Re-check with new meds and age
Cues and rituals	Schedule cleared; circles reviewed	Sober days feel fine	Triggers shift: meaning, loss [4]	Same plan, rehearsed
Integration work	Integration first; journal, therapist	Backlog cleared; ongoing practice [3]	Reflective practice weekly	Reflection stays part of life
Sleep, calm, perception	Sleep first; no cannabis	Perception steady; sleep restored	Anxiety plan, clinician-led	Stress plan, sleep habits
Natural access practice	Daily sit; awe; vulnerability	Daily practice; tradition chosen	Practice deepens; retreat, teacher [5]	Practice as a way of life
Meaning and Manning	Meaning crisis: hold, don't solve	Identity beyond the sessions	Manning: guide, integration peer [6]	Mentor or run a group

The seven shifts

1. **Year 3, the mood decision and any therapeutic decision.** If depression or anxiety outlasted early recovery, treat it directly, with 5-MTHF first for MTHFR variants and a psychiatrist for anything clinical (Supp. Ch. 27 §4.4). If you are considering therapeutic psilocybin, the Kernel's conditions apply: specialist collaboration, full disclosure, HPPD and psychosis clearance (Supp. Ch. 27 §7), and the availability picture has been changing, so check it fresh.
2. **Year 3, the stack moves from building to upkeep.** The Kernel says 5-HT2A receptor density largely recovers within months and HPPD substantially resolves in most cases by 6 to 24 months (Supp. Ch. 26 §3). Retest labs (Supp. Ch. 5 Step 1a) and step down toward maintenance. The Trinity chapter says supplements are taken until stable, then tapered and resumed if the system destabilizes; Main Book Ch. 2 treats MTHFR support as maintenance, not cure. Step down to maintenance, not to zero.
3. **Year 3, the integration backlog is cleared and integration becomes a practice.** The Kernel says integration is not a phase that ends: the first year is the most intensive, then it becomes ongoing reflection (Supp. Ch. 26 §7). By year

3 the backlog should be metabolized and the work should be ordinary reflective life.

4. **Year 5, triggers shift to meaning and loss.** The Kernel says the pull is existential restlessness, not physical craving, and that the sober world can feel narrow (Supp. Ch. 27 §1.4). By year 5, the exposure is major losses, life transitions, and the return of that restlessness. Keep the contemplative practice and Protocol 21 ready. This shift is extrapolation.
5. **Year 5, the practice deepens.** The Kernel says meditation reliably reaching deeper states takes consistent daily practice over months to years (Supp. Ch. 26 §7), and that one tradition practiced consistently goes deeper than sampling many (Supp. Ch. 26 §6). By year 5 this is a natural time for a teacher, a community, or a retreat.
6. **Year 5, Manning.** This is the Trinity's third stage (Supp. Ch. 2). This is extrapolation: integration circles, peer support, and guiding others through the same territory, with lived knowledge of both the opening and the aftermath.
7. **Year 10, the psychosis rule holds for life.** The Kernel calls the contraindication absolute regardless of dose or setting, and says HPPD is a bar to therapeutic use (Supp. Ch. 27 §0, §7). Any future decision about psychedelics of any kind stays with specialists and depends on that history.

What is sourced and what is extrapolated. *Shifts 3, 5, and 7 rest directly on Kernel text. Shifts 1 and 2 apply Kernel rules at a timing chosen for this guide. Shifts 4 and 6 are extrapolations. The Kernel's detailed psilocybin timeline ends at months 6 to 24, and its WHEN Correlator puts deep-root reversal at 2 to 5 or more years for heavy long-term use. Years 3, 5, and 10 are therefore projections.*

5. What outcome to expect

The short version

If you do the route above, with the psychosis screen first, all psychedelics and cannabis stopped, sleep repaired, the foundation built, the integration backlog worked through with a therapist, any HPPD understood, underlying conditions treated, and natural access built through daily practice, this is the outcome the Kernel projects:

- **Weeks 1 to 8:** HPPD, if present, often eases, sleep stabilizes, and the integration work begins to produce clarity.
- **Months 1 to 6:** 5-HT2A receptor density largely recovers, HPPD is diminishing for most people, and the meaning the sessions opened begins to become part of your life.
- **Months 6 to 24 and beyond:** most HPPD has substantially resolved, integration continues, and the practices you built are, in the Kernel's words, "not substitutes" but "the real thing."
- **By years 3 to 5 the work is maintenance and building. By year 10 you are a steward,** carrying a small set of standing safeguards.

The Kernel does not promise zero risk, and it does not claim that all HPPD resolves. It says a small minority of cases stay clinically significant, and that psychosis, if it occurred, is a psychiatric matter first.

Milestones, in order

Milestone	When	Expected outcome	Source	Basis
Afterglow	Days 1–3	BDNF-enhanced plasticity. The best integration window: journal, reflect, avoid demanding input. The window is shorter than for LSD.	Supp. Ch. 27 §3.2	Kernel projection
Sleep and HPPD check	Week 1	Sleep disruption is common after high-dose sessions. Assess HPPD if visual phenomena appear. Stop cannabis.	Supp. Ch. 27 §3.2; Ch. 26 §3.1	Kernel projection
Integration sprint	Weeks 2–8	Integration is the primary activity. HPPD, if present, often reduces. Therapist and community involved.	Supp. Ch. 27 §3.2	Kernel projection
Receptor recovery	Months 1–6	5-HT2A receptor system largely recovered. HPPD diminishing for most. Meaning beginning to metabolize into life.	Supp. Ch. 26 §3.1	Kernel projection
HPPD resolution	Months 6–24+	Most HPPD substantially resolved. A small minority persist at clinically significant levels.	Supp. Ch. 26 §§3.1, 4.2	Kernel projection
Ongoing integration	Months 6–24+	Material slowly metabolized into life wisdom. The meaning question may remain active.	Supp. Ch. 26 §3.1	Kernel projection
Deep-root reversal	2–5+ years (heavy long-term use)	Prefrontal recovery and epigenetic reversal continue. Some changes may be partial.	Supp. Ch. 36	Kernel projection
Steward phase	Years 3–10	Repair tracks at maintenance. Contemplative practice. Service. Standing safeguards.	Section 4 of this guide	Extrapolated

The Kernel's 12-month numbers: none for psilocybin

The Kernel has no psilocybin case study and gives no psilocybin-specific projections, so there is no 12-month table here, and this guide will not make one up. The nearest profiles in Supplemental Chapter 2 concern other substances: Case 06 (MDMA) is a serotonin-system profile with a 68% cessation or significant reduction projection against a 35% baseline, and Case 09 (ketamine) is a trauma and dissociation profile with 67% significant PTSD symptom reduction at 6 months against a 20% baseline. Neither is a prediction for psilocybin, and both are archetype projections with the Kernel's own caveats. What the Kernel does offer for psilocybin is a timeline (above) and the observation that HPPD generally improves with cessation.

What changes the outcome

- **Ignoring psychosis history,** or continuing after a psychotic-like episode.

- **Continuing cannabis.** The Kernel calls it the most reliable HPPD and depersonalization aggravator.
- **Using again to make sense of the last experience.** The Kernel names this the trap that produces accumulation.
- **Skipping integration** and treating the sessions as finished events. The backlog is the main problem.
- **Sleep loss, anxiety, caffeine, and screens late at night,** which worsen HPPD and depersonalization.
- **A microdose that never ends:** intolerance of sober days, escalation, or an untreated condition it is masking.
- **Treating a psychotic episode or persisting hallucinations as "HPPD."** Any loss of reality testing needs urgent evaluation.
- **Adding 5-HTP too soon, or with serotonergic medication.**
- **A lapse.** The Kernel treats it as information, not judgment (Protocol 21). Ask what state was underneath it, keep a sitter, and get help for any frightening experience.

How to read the evidence behind the outcomes

The Main Book marks claims with an Evidence Tier: Established, Probable, Emerging, Author/System Experience, and Controversial or Mixed. This guide's reading: the psychosis contraindication, the mushroom-misidentification danger, and the MAOI and tramadol interaction are clinically well founded. The Kernel's HPPD prevalence figure (4 to 5 percent), its HPPD medication notes (clonazepam, lamotrigine), and its advice to avoid SSRIs and conventional antipsychotics in HPPD rest on limited case-level evidence, and the Kernel itself says SSRIs mostly dampen psilocybin, so treat the SSRI question as one for a psychiatrist. The finding that mystical-type experience predicts therapeutic outcomes is from clinical trials, but it describes supervised therapeutic use, not recreational use. The supplement stack, the BDNF claims, the natural-access comparisons to meditative states, the percentage analogs, and the years 3 to 10 trajectory sit lower on that scale, so bring them to your clinician as questions, not as facts.

Take these to your clinician

- An honest account of your use: how often, what amounts, which species or products, whether you microdosed, any other psychedelics or cannabis, and any frightening experiences.
- Any personal or family history of psychosis, schizophrenia, or bipolar disorder, and any time you lost track of what was real, so a psychiatric evaluation can be arranged if needed.
- Any persisting visual phenomena or feelings of detachment, with a description of what you see and whether you know it is not real.
- Every medication and supplement you take, especially MAOIs, tramadol, lithium, or any serotonergic drug, and before any 5-HTP.

- Your HTR2A, COMT, and MTHFR results, what your sessions were treating (depression, trauma, anxiety, ADHD), and whether a psychedelic-informed therapist can help with integration.